

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CMS COULD USE MEDICARE DATA
TO IDENTIFY INSTANCES OF
POTENTIAL ABUSE OR NEGLECT**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Joanne M. Chiedi
Acting Inspector General**

**June 2019
A-01-17-00513**

Office of Inspector General

<https://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nation-wide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the healthcare industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief

Date: June 2019

Report No. A-01-17-00513

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's vulnerable populations, including the elderly and individuals with developmental disabilities. OIG is committed to detecting and combating such abuse and neglect. Accordingly, we prepared this audit report after identifying a significant number of Medicare claims submitted for the treatment of injuries related to potential abuse and neglect.

Our objectives were to determine (1) the prevalence of incidents of potential abuse or neglect of Medicare beneficiaries, (2) who may have perpetrated those incidents and where they occurred, (3) whether the incidents were reported to law enforcement officials, and (4) whether the Centers for Medicare & Medicaid Services (CMS) also identified similar incidents of potential abuse or neglect during our audit period and took action to address them.

How OIG Did This Review

Our review covered 34,664 Medicare inpatient and outpatient claims totaling \$99.6 million for services provided from January 2015 through June 2017 to treat beneficiaries with at least 1 of 17 diagnosis codes related to potential physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment. We selected a stratified random sample of 100 Medicare claims and then reviewed the associated medical records to obtain evidence of potential abuse or neglect.

CMS Could Use Medicare Data To Identify Instances of Potential Abuse or Neglect

What OIG Found

We identified 34,664 Medicare claims for our audit period that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries. We estimated 30,754 of these Medicare claims were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our population associated with incidents of potential abuse or neglect, 2,574 were allegedly perpetrated by a healthcare worker, 3,330 were related to incidents that occurred in a medical facility, and 9,294 were related to incidents that were not reported to law enforcement.

CMS did not identify similar incidents of potential abuse or neglect during our period of review, but it did take some corrective actions in response to the Early Alert we sent to CMS. CMS did not identify the Medicare claims that indicate potential abuse or neglect because, according to CMS officials, it did not extract data consisting of Medicare claims containing the 17 diagnosis codes related to abuse or neglect. The lack of a data extract impeded the ability of CMS or of public and patient safety organizations to pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare beneficiaries.

What OIG Recommends and CMS Comments

We recommend that CMS (1) compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect; (2) use that complete list to conduct periodic data extracts of all Medicare claims containing at least one of those codes; (3) inform States that the extracted Medicare claims data are available to help States ensure compliance with their mandatory reporting laws; and (4) assess the sufficiency of existing Federal requirements, such as conditions of participation and section 1150B of the Social Security Act, to report suspected abuse and neglect of Medicare beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional authorities as appropriate.

In written comments on our draft report, CMS concurred with our fourth recommendation but did not concur with our first three recommendations. Specifically, CMS stated that claims data may not be timely enough to address acute problems in identifying and addressing potential abuse or neglect of Medicare beneficiaries. We respectfully disagree with CMS and continue to recommend the use of the Medicare claims data to identify and address potential abuse and neglect of beneficiaries.

TABLE OF CONTENTS

INTRODUCTION	1
Why We Did This Review	1
Objectives.....	1
Background	1
The Medicare Program	1
The Social Security Act	2
The Older Americans Act	2
The Elder Justice Act	2
Delegation to CMS of the Enforcement of Section 1150B of the Social Security Act.....	3
Conditions of Participation	3
HHS Strategic Plan.....	4
State Survey Agencies	4
Medicaid Fraud Control Units.....	5
Adult Protective Services Programs.....	5
Mandatory Reporting	5
Recent OIG Related Reviews.....	5
How We Conducted This Review	6
FINDINGS.....	7
Medicare Claims Data Identified Many Incidents of Potential Abuse and Neglect and Most Sampled Medical Records Contained Evidence of Potential Abuse or Neglect	7
Medicare Claims Data Identified More Than 30,000 Incidents of Potential Abuse or Neglect	7
More Than 90 Percent of Sampled Medical Records Contained Evidence of Potential Abuse or Neglect.....	12
Healthcare Workers Were Sometimes the Likely Perpetrators of Incidents of Potential Abuse or Neglect and Most Incidents Occurred in Settings Other Than Medical Facilities	13
Healthcare Workers Were Sometimes the Likely Perpetrators of Incidents of Potential Abuse or Neglect	13
Most Incidents of Potential Abuse or Neglect Occurred in Settings Other Than Medical Facilities.....	14

Law Enforcement Was Not Always Alerted to Incidents of Potential Abuse or Neglect	17
CMS’s Failure To Use All Medicare Claims Data Represents a Missed Opportunity To Identify Potential Cases of Abuse or Neglect	19
RECOMMENDATIONS	20
CMS COMMENTS	21
OFFICE OF INSPECTOR GENERAL RESPONSE	22
APPENDICES	
A: Audit Scope and Methodology	24
B: Related Office of Inspector General Reports.....	26
C: Statistical Sampling Methodology	27
D: Sample Results and Estimates.....	29
E: The Number of Medicare Claims Associated With Incidents of Potential Abuse or Neglect of Medicare Beneficiaries Who Were Military Veterans.....	30
F: The Number Per State of Medicare Claims for the Treatment of Potential Abuse or Neglect	32
G: Detailed Example of an Incident of Potential Neglect	33
H: The Number of Medicare Claims Indicating Potential Child Abuse or Neglect.....	34
I: A List Provided by CMS of 39 Diagnosis Codes That Indicate Potential Abuse or Neglect of Adult or Child Medicare Beneficiaries	37
J: CMS Comments	39
Acknowledgments.....	43

INTRODUCTION

WHY WE DID THIS REVIEW

This audit report is one of a series of Office of Inspector General (OIG) reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's vulnerable populations, including the elderly and individuals with developmental disabilities. We are committed to detecting and combating such abuse and neglect.

Accordingly, we prepared this audit report after identifying a significant number of Medicare claims that healthcare workers submitted for the treatment of injuries related to the potential abuse and neglect of Medicare beneficiaries.¹ We performed this review because of our preliminary findings regarding Medicare beneficiaries residing at skilled nursing facilities (SNFs). Those findings were troubling enough that we expanded our review to include all Medicare beneficiaries rather than just those Medicare beneficiaries residing in SNFs.

OBJECTIVES

Our objectives were to determine (1) the prevalence of incidents of potential abuse or neglect of Medicare beneficiaries, (2) who may have perpetrated those incidents and where they occurred, (3) whether the incidents were reported to law enforcement officials, and (4) whether the Centers for Medicare & Medicaid Services (CMS) also identified similar incidents of potential abuse or neglect during our audit period and took action to address them.

BACKGROUND

The Medicare Program

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 years and older, people with disabilities, and people with end-stage renal disease. CMS administers Medicare. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services, physician services, laboratory services, and ambulance services. There was a monthly average of 57.1 million Medicare beneficiaries in 2016.

¹ This audit report includes incidents involving all types of Medicare beneficiaries, regardless of their age or the reason for their Medicare coverage. The list of diagnosis codes used for this audit report uses only those codes that specifically indicate potential abuse or neglect. For the purpose of this report, an "incident" is defined as a Medicare claim involving the treatment of potential abuse or neglect.

The Social Security Act

Section 2011 of the Act defines an elder as an individual aged 60 years or older and abuse as “the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.” Section 2011 defines neglect as “the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder.”² It also defines exploitation as “the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.”

The Older Americans Act

The Older Americans Act, P.L. No. 89-73 (enacted July 14, 1965) was reauthorized as P.L. No. 114-144 (April 19, 2016) with a variety of objectives, including the protection of older persons from abuse, neglect, and exploitation. The Older Americans Act created the National Aging Network comprising the Administration on Aging at the Federal level, Units on Aging at the State level, and Area Agencies on Aging at the local level. This network provides funding, based primarily on the percentage of an area’s population aged 60 years and older, for nutrition and supportive home and community-based services, disease prevention and health promotion services, elder rights programs, the National Family Caregiver Support Program, and the Native American Caregiver Support Program.

The Elder Justice Act

The Elder Justice Act (EJA), enacted as part of the Patient Protection and Affordable Care Act (ACA)³ on March 23, 2010, contains provisions that address certain public health and social services approaches to prevention, detection, and treatment of elder abuse primarily under the Department of Health and Human Services’ (HHS’s) authority and administration. The EJA authorized several grant programs, such as a new State grant program for States’ adult protective services (APS). It also established requirements for reporting of crimes in long-term-care facilities in section 1150B, “Reporting to Law Enforcement of Crimes Occurring in Federally Funded Long-Term Care Facilities.”⁴ In addition, the EJA created advisory bodies on elder abuse

² This definition also includes self-neglect.

³ P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010). Subtitle H of the ACA of 2010 is also known as the EJA of 2009.

⁴ Section 6703(b)(3) of the ACA.

within HHS: the Elder Justice Coordinating Council and the Advisory Board on Elder Abuse, Neglect, and Exploitation.⁵

Delegation to CMS of the Enforcement of Section 1150B of the Social Security Act

Section 1150B of the EJA states: “Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.”⁶ This section applies to a long-term-care facility if it is determined that the facility received at least \$10,000 in Federal funds during the preceding year.

In June 2017, CMS began working with the HHS Office of the Secretary to receive the delegation of authority to enforce the Act section 1150B. CMS officials stated that they have not taken action under section 1150B because they have not identified instances in which a covered individual failed to report a crime, such as an incident of potential abuse or neglect of a Medicare beneficiary. CMS officials also acknowledged that the *CMS State Operations Manual* (SOM) did not include references to section 1150B until March 8, 2017;⁷ however, they noted that CMS had issued the “CMS State Survey Agency Directors’ Letter” (S&C-11-30-NH) on June 17, 2011.⁸ This letter details the requirements and sanctions contained in section 1150B and instructs the State Survey Agencies, which fulfill certain oversight functions, to process reports received under section 1150B in accordance with existing CMS and State policies and procedures.⁹ CMS officials stated that they have taken additional actions to protect residents in nursing homes by adding section 1150B requirements to training courses and issuing supporting interpretive guidance and training to surveyors. During this audit, CMS has continued to work with the HHS Office of the Secretary to receive this delegation and on drafting regulations regarding the enforcement of section 1150B.

Conditions of Participation

CMS developed the CoPs that healthcare organizations must meet to participate in Medicare and Medicaid. These CoPs establish health and safety standards, which are the foundation for

⁵ EJA §§ 2021 and 2022.

⁶ A covered individual is defined in 42 U.S.C 1320b-25(a)(3) as “each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of determination”

⁷ These references became effective November 28, 2017.

⁸ The SOM provides guidance on the conditions of participation. Section 1150B of the EJA was not added to the conditions of participation (CoPs) until November 2016 (81 Fed. Reg. 68688 (Oct. 4, 2016)).

⁹ Survey Agencies have used existing 42 CFR § 483.13(c) deficiency citations.

improving quality and protecting the health and safety of beneficiaries. These CoPs are contained in the Code of Federal Regulations (CFR) under Title 42. The CoPs for long-term-care facilities (nursing homes and SNFs) state that when there is an allegation of abuse or neglect, the facility must “report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.” The long-term-care facility must report the results of all investigations to the administrator and to other officials, including the State agency, in accordance with State law.¹⁰

HHS Strategic Plan

HHS’s Strategic Plan for fiscal years 2018 through 2022 stipulates that several of the strategic objectives are related to the health, safety, and well-being of individuals. For example, Strategic Objective 3.2¹¹ is to “safeguard the public against preventable injuries and violence or their results.” Two of HHS’s strategies to achieve this objective are to “expand knowledge about important abuse intervention models to enhance evidence-based services for older adults and adults with disabilities” and to “assess healthcare use and costs associated with violence and unintentional injury, including patient safety events that occur in healthcare settings, to inform actions to prevent injury and violence and describe the return on investment of public health action.”

State Survey Agencies

CMS is responsible for overseeing compliance with Medicare health and safety standards. CMS delegates a variety of tasks related to this oversight to the State Survey Agencies (the Act § 1864). One of these tasks is to conduct investigations and fact-finding surveys to determine how well healthcare providers comply with their applicable CoPs, including the reporting of potential abuse or neglect. When the State Survey Agencies or CMS Regional Office substantiates a finding of abuse, the State Survey Agency or Regional Office must report the substantiated finding to law enforcement and, if appropriate, the States’ Medicaid Fraud Control Units (MFCUs) (SOM, chapter 5, § 5330). In fiscal year 2016, Federal funding of State Survey Agencies was an estimated \$397 million.

¹⁰ 42 CFR 483.12, revised effective November 28, 2016.

¹¹ HHS Strategic Plan. Available online at <https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html>. Accessed on October 16, 2018.

Medicaid Fraud Control Units

Each State's MFCU investigates and prosecutes a variety of healthcare-related crimes, including patient abuse or neglect in healthcare facilities.¹² These healthcare facilities include SNFs that receive Medicare reimbursement. MFCUs operate in 49 States and the District of Columbia. MFCUs, which are usually a part of the State Attorney General's office, employ teams of investigators, attorneys, and auditors. OIG, in exercising oversight of MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with Federal requirements, and administers a Federal grant award to fund a portion of each MFCU's operational costs.

Adult Protective Services Programs

Each State has an APS program authorized by State law. State and local APS programs are considered among the first responders to reports of abuse, neglect, or exploitation of adults.¹³ Upon receiving a report of abuse involving an elderly or vulnerable adult, APS programs typically provide services, including an investigation of the allegation, evaluation of client risk and mental capacity, and ongoing monitoring of the delivery of services. APS programs also work closely with law enforcement if criminal abuse against elderly or vulnerable adults is suspected.

Mandatory Reporting

All States require certain individuals by law to report suspected abuse, neglect, or exploitation of elderly or vulnerable adults to APS. This is referred to as "mandatory reporting" and those required to make the reports as "mandatory reporters." Some States require only certain professionals to report suspected abuse, neglect, or exploitation. Other States require all citizens to report suspected abuse, neglect, or exploitation.

Recent OIG Related Reviews

OIG is committed to protecting beneficiary health and safety and has issued numerous reports that have detailed problems with the quality of care and the reporting and investigation of potential abuse or neglect at group homes, nursing homes, and SNFs.¹⁴ For example, OIG's

¹² The Act § 1903(q).

¹³ Each State defines "adult" differently for APS purposes. For example, some States define an adult eligible for APS services as anyone aged 18 years or older, but other States define such an adult as anyone aged 60 years or older. Some States also require that the adults be vulnerable because of a physical or mental illness or a disability. The Medicare beneficiaries in our population ranged in age from 18 to 106 years.

¹⁴ See Appendix B for a list of previously issued OIG reports on this issue.

recent audit reports on critical incident¹⁵ reporting at group homes showed that group home providers failed to report up to 15 percent of critical incidents to the appropriate State agencies (A-01-14-00002, A-01-14-00008, A-01-16-00001). OIG's study of adverse events¹⁶ in SNFs found that an estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays (OEI-06-11-00370). These adverse events included infections, pressure ulcers, and medication-induced bleeding. We determined through our medical record review that 69 percent of these patient-harm events could have been prevented if the SNF had provided better care. More than half of the residents harmed during their SNF stays required hospital care to treat the adverse event.

In addition, we issued an Early Alert to CMS that was released in August 2017 (A-01-17-00504). The Early Alert notified CMS of the severity of the incidents we identified involving 12 diagnosis codes used by the treating healthcare providers that specifically indicated potential physical or sexual abuse or neglect of Medicare beneficiaries.

We concurrently developed an audit report (A-01-16-00509) that excluded the 12 diagnosis codes in the Early Alert and contained 580 diagnosis codes that we determined to be indicative of high risk for potential abuse or neglect of Medicare beneficiaries. Our list of 580 diagnosis codes included diagnosis codes for head injuries, bodily injuries, and safety and medical issues. We anticipate this report to be released at the same time as this review.

HOW WE CONDUCTED THIS REVIEW

Our review covered 34,664¹⁷ inpatient and outpatient claims totaling \$99.6 million for services provided to Medicare beneficiaries from January 2015 through June 2017 to treat beneficiaries with at least 1 of 17 diagnosis codes related to abuse or neglect.¹⁸ We selected a stratified random sample of 100 Medicare claims and then reviewed the associated medical records to determine whether they contained evidence of potential abuse or neglect, who may have perpetrated those incidents, where they occurred, and whether law enforcement was alerted. The 17 codes specifically indicate potential physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment. We also discussed with CMS the steps it has taken to identify incidents of potential abuse or neglect of Medicare beneficiaries.

¹⁵ The general definition of "critical incidents" includes but is not limited to events involving facility patients or residents who suffered serious injuries or illness requiring treatment at an emergency room (ER).

¹⁶ The term "adverse event" describes harm to a patient or resident as a result of medical care or in a healthcare setting.

¹⁷ There were 13,565 Medicare claims in 2015; 13,999 in 2016; and 7,100 for the first 6 months of 2017.

¹⁸ These 17 diagnosis codes were assigned by the physicians who treated the Medicare beneficiaries. We could not identify Medicare beneficiaries who were injured but not treated by a physician because there would have been no record of their treatment. Therefore, there is a risk that other Medicare beneficiaries who were potentially abused or neglected remain unidentified.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains details of our audit scope and methodology. Appendix C contains our statistical sampling methodology. Appendix D contains our sample results and estimates.

FINDINGS

We identified 34,664 Medicare claims that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries from January 1, 2015, through June 30, 2017. We estimated that 30,754 of these Medicare claims were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our population associated with incidents of potential abuse or neglect, 2,574 were allegedly perpetrated by a healthcare worker, 3,330 were related to incidents that occurred in a medical facility, and 9,294 were related to incidents that were not reported to law enforcement. CMS did not identify similar incidents of potential abuse or neglect during our period of review, but it did take some corrective actions in response to our Early Alert to CMS.

CMS did not identify the Medicare claims that indicate potential abuse or neglect because, according to CMS officials, it did not extract data consisting of Medicare claims containing the 17 diagnosis codes related to abuse or neglect. The lack of a data extract impeded the ability of CMS and public and patient safety organizations to pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare beneficiaries.

MEDICARE CLAIMS DATA IDENTIFIED MANY INCIDENTS OF POTENTIAL ABUSE AND NEGLECT AND MOST SAMPLED MEDICAL RECORDS CONTAINED EVIDENCE OF POTENTIAL ABUSE OR NEGLECT

Medicare Claims Data Identified More Than 30,000 Incidents of Potential Abuse or Neglect

We identified 34,664 Medicare claims¹⁹ that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries. These claims related to 29,431 Medicare beneficiaries²⁰ who received medical treatment during our audit

¹⁹ On the basis of our sample results, we estimated that approximately 2,511 of the 34,664 Medicare claims were associated with incidents of potential abuse or neglect that involved Medicare beneficiaries who were also military veterans (Appendix E).

²⁰ Of these 29,431 Medicare beneficiaries, 3,402 had more than one claim and 464 died at a medical facility during the treatment of their injuries.

period at a variety of medical facilities in all 50 States, the District of Columbia, and Puerto Rico (Appendix F). The instances of potential abuse or neglect were indicated on the Medicare claims by the use of at least 1 of 17 diagnosis codes that indicate abuse or neglect (Table 1).

Table 1: Number of Medicare Claims Containing a Diagnosis Code Indicating Potential Abuse or Neglect During the Period From January 2015 Through June 2017

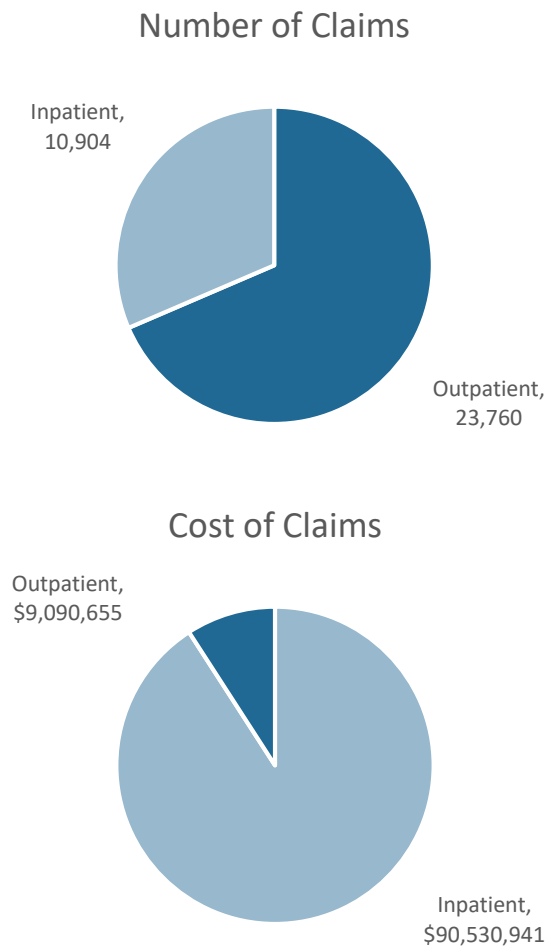
Diagnosis Code	Description	Number of Inpatient Claims	Number of Outpatient Claims	Total Number of Claims
T7411XA	Adult physical abuse, confirmed, initial encounter	837	2,661	3,498
T7601XA	Adult neglect or abandonment, suspected, initial encounter	2,730	713	3,443
T7621XA	Adult sexual abuse, suspected, initial encounter	465	2,751	3,216
T7421XA	Adult sexual abuse, confirmed, initial encounter	211	2,809	3,020
99581	Adult physical abuse	627	2,192	2,819
T7611XA	Adult physical abuse, suspected, initial encounter	1,419	1,259	2,678
Z0441	Encounter for examination and observation following alleged adult rape	57	2,103	2,160
V715	Observation following rape	47	2,095	2,142
T7491XA	Unspecified adult maltreatment, confirmed, initial encounter	258	1,771	2,029
T7401XA	Adult neglect or abandonment, confirmed, initial encounter	1,193	832	2,025
99584	Adult neglect (nutritional)	1,256	569	1,825
99580	Adult maltreatment, unspecified	477	1,061	1,538
T7691XA	Unspecified adult maltreatment, suspected, initial encounter	917	502	1,419
Z0471	Encounter for examination and observation following alleged adult physical abuse	104	984	1,088
99583	Adult sexual abuse	143	897	1,040

Continued on the next page

99585	Other adult abuse and neglect	350	325	675
V7181	Abuse and neglect	38	422	460
Claims with more than one diagnosis code		(225)	(186)	(411)
Total		10,904	23,760	34,664

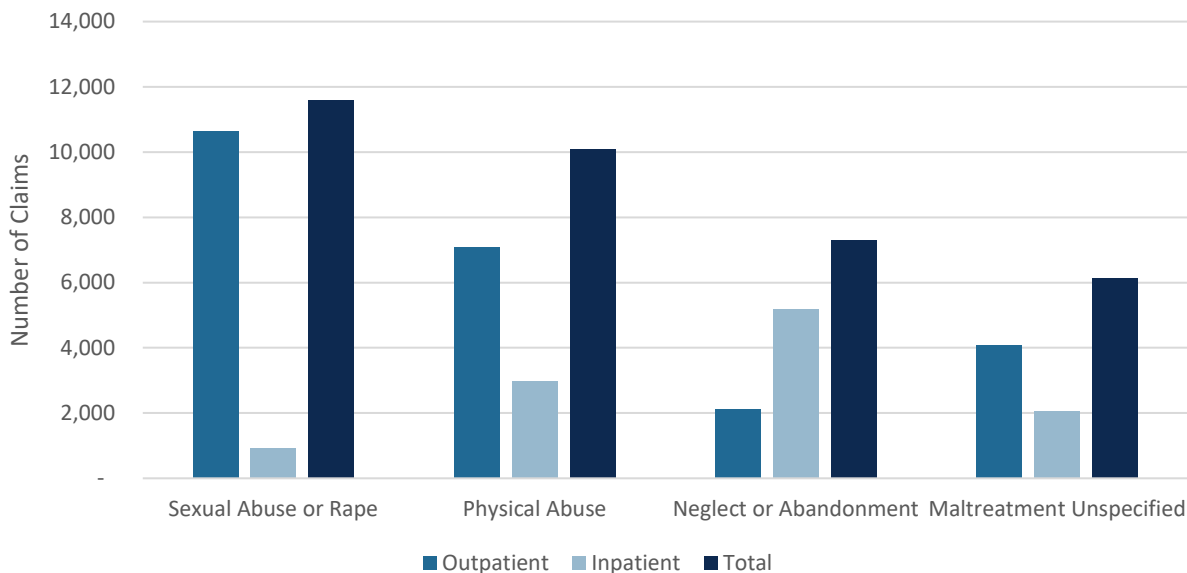
Most of the Medicare claims were for treatment provided in outpatient settings (69 percent), and the remaining claims were for treatment provided in inpatient settings (31 percent). The total cost of the 23,760 outpatient claims for the treatment of the Medicare beneficiaries' injuries was \$9,090,655, an average of \$383 per claim; the total cost of the 10,904 inpatient claims for the treatment of the Medicare beneficiaries' injuries was \$90,530,941, an average of \$8,303 per claim (Figure 1).

Figure 1: Inpatient and Outpatient Medicare Claims Associated With Potential Abuse and Neglect That Were Submitted by the Treating Facilities



On the basis of their descriptions, we categorized the 17 diagnosis codes into four categories: sexual abuse or rape, physical abuse, neglect or abandonment, and maltreatment unspecified (Figure 2).

Figure 2: Claims by Diagnosis Category



Using the claims data, we also reviewed demographic data such as the beneficiary's age at the time of the claim and sex. The ages of beneficiaries were distributed over all ages of adulthood (Figure 3) despite the fact that most Medicare beneficiaries are over age 65. In addition, female beneficiaries had the majority of abuse or neglect claims (Figure 4 on the next page).

Figure 3: Ages of Beneficiaries With Claim Types

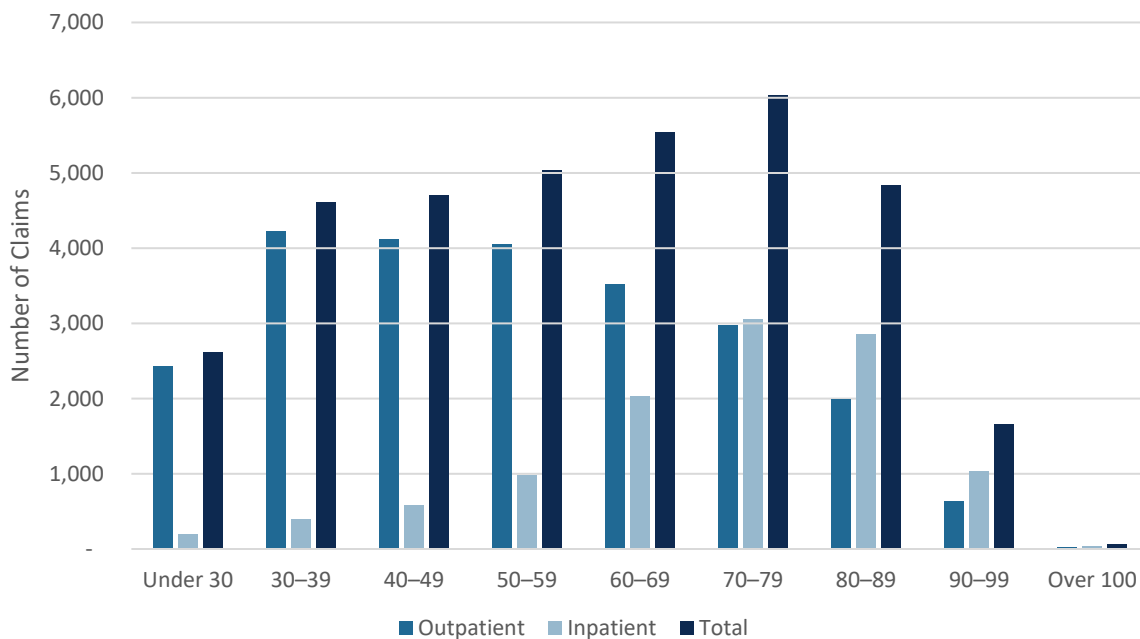
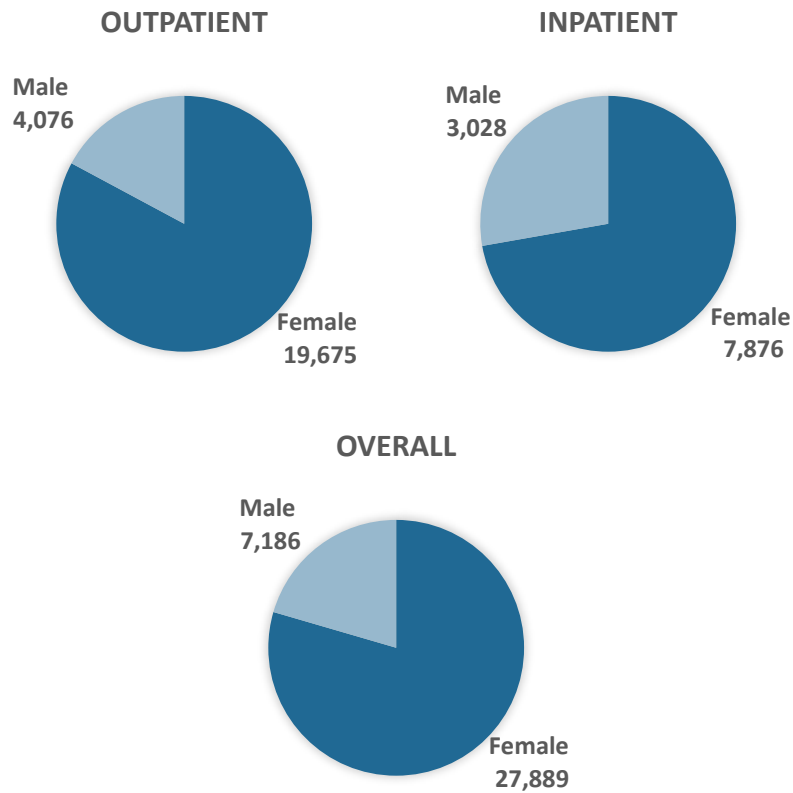


Figure 4: Sex of Beneficiaries by Claim Type



**A Representative Example of an Incident of Potential Abuse
Requiring Inpatient Treatment**

A beneficiary was treated as an inpatient at a hospital for a variety of medical problems, including potential physical abuse. The beneficiary stated that her husband struck her in the cheek area the preceding day. The beneficiary also stated that her husband had been emotionally abusing her. The hospital treated the beneficiary for her injuries and contacted APS and law enforcement. The beneficiary was discharged to her home. (See Photograph 1 on the next page.)

Photograph 1: Beneficiary's Facial Injury Sustained During the Incident of Potential Abuse



A Representative Example of an Incident of Potential Abuse Requiring Outpatient Treatment

A beneficiary was treated as an outpatient at a hospital after a potential sexual assault. The beneficiary was complaining of vaginal pain and painful urination. The beneficiary was examined by a sexual assault nurse examiner who identified physical trauma, including the bruising of both breasts and two tears of the vagina. The hospital treated the beneficiary for her injuries and contacted law enforcement. The beneficiary was discharged to her home.

See Appendix G for an additional detailed example of an incident of potential neglect. See Appendix H for detailed information about beneficiaries who were children at the time of their abuse but not included in our sample because their specific diagnosis codes were outside of the scope of our audit.

More Than 90 Percent of Sampled Medical Records Contained Evidence of Potential Abuse or Neglect

Of the 100 Medicare claims we sampled, 94 had medical records that contained evidence of potential abuse or neglect. This evidence included, but was not limited to, witness statements and photographs. We were unable to determine whether the remaining six Medicare claims were for treatment of injuries as a result of potential abuse or neglect because of insufficient or unclear documentation in the medical records. On the basis of our sample results, we estimated that 30,754 of the 34,664 Medicare claims in our population had medical records that contained evidence of potential abuse or neglect. For the remainder of this report, when

we talk about the claims sampled, we will refer to the 94 claims associated with incidents of potential abuse or neglect as shown in their medical records in our sample of 100 claims.

HEALTHCARE WORKERS WERE SOMETIMES THE LIKELY PERPETRATORS OF INCIDENTS OF POTENTIAL ABUSE OR NEGLECT AND MOST INCIDENTS OCCURRED IN SETTINGS OTHER THAN MEDICAL FACILITIES

Healthcare Workers Were Sometimes the Likely Perpetrators of Incidents of Potential Abuse or Neglect

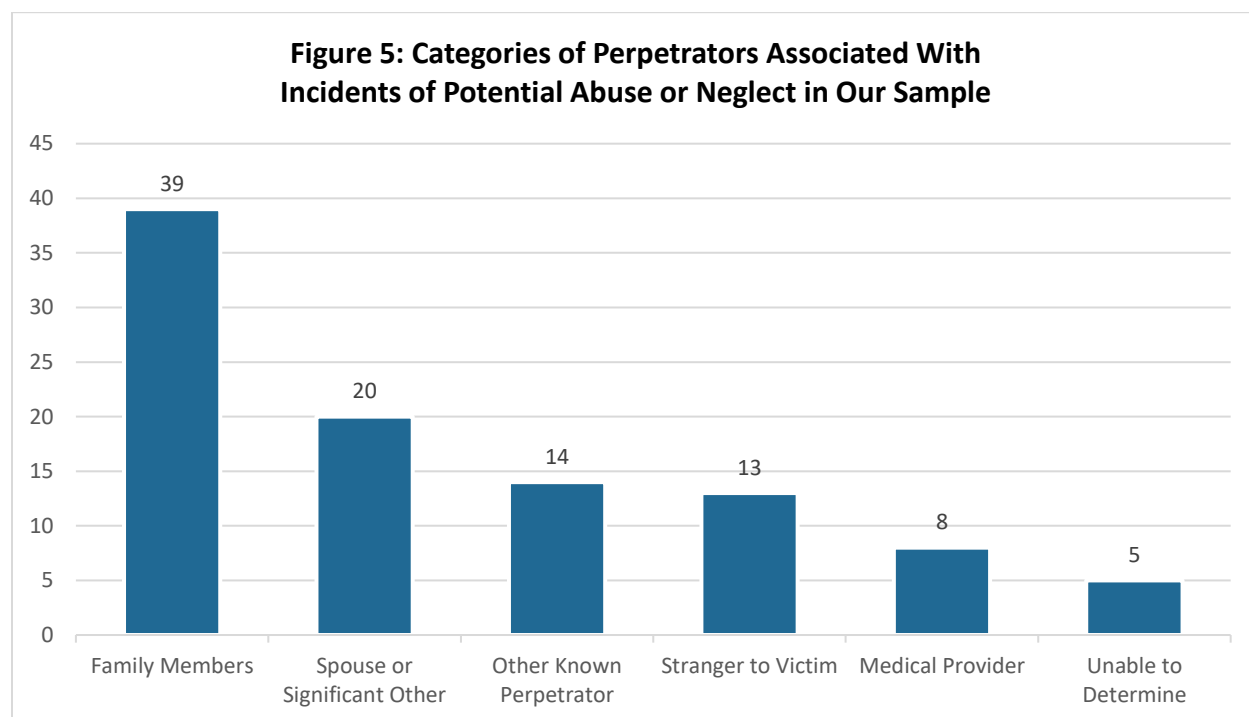
Some of the incidents of potential abuse or neglect associated with the Medicare claims we reviewed involved alleged perpetrators who were healthcare workers. Specifically, we determined that for 8 of the 94 Medicare claims in our sample, the alleged perpetrator was a healthcare worker. On the basis of our sample results, we estimated that there were 2,574 Medicare claims associated with incidents of potential abuse or neglect in which the alleged perpetrator was a healthcare worker.

A Representative Example of an Incident of Potential Abuse in Which the Alleged Perpetrator Was a Healthcare Worker

A nonverbal male beneficiary was treated as an inpatient for potential abuse. The beneficiary was brought to the hospital by an ambulance from the long-term acute-care hospital where he was being treated for numerous medical issues. The beneficiary's family stated that they found him on multiple occasions lying in his own fecal matter, which had sometimes hardened on his body. The beneficiary had serious sacral and scrotal bed sores and deep tissue injuries to his left foot and heel. The family also stated that there were instances in which issues with the beneficiary's feeding tube were not addressed in a timely manner. The family further stated that an aide at the long-term-care hospital was overly aggressive when turning the beneficiary, and that the beneficiary was frightened of the aide. The family was concerned for the beneficiary's safety and called an abuse hotline and law enforcement. The beneficiary was discharged to a SNF and died 23 days after discharge from the hospital.

Of the 94 Medicare claims associated with incidents of potential abuse or neglect in our sample, 39 were associated with incidents involving family members, 20 involved spouses or significant others, 14 involved other known alleged perpetrators (e.g., an acquaintance or self-abuse), and 13 were incidents with an alleged perpetrator who was a stranger to the

victim.²¹ We were unable to determine who the alleged perpetrator was for the remaining five Medicare claims in our sample (Figure 5).²²



Most Incidents of Potential Abuse or Neglect Occurred in Settings Other Than Medical Facilities

Section 1150B of the Act²³ and the CoPs contained in CFR Title 42 for long-term-care facilities, such as nursing homes and SNFs, include reporting requirements for incidents of suspected abuse or neglect. For these facilities, covered individuals are required to report suspected abuse, neglect, or exploitation within 2 hours if the incident resulted in serious bodily injury and within 24 hours if the incident did not result in serious bodily injury.

²¹ According to the U.S. Department of Justice, Bureau of Justice Statistics' Special Report, *Violence-Related Injuries Treated in Hospital Emergency Departments* (Aug. 1997) (Table 6), 7.3 percent of victims were injured by spouses or ex-spouses, 2.8 percent by parents, .8 percent by children, 4.1 percent by other relatives, 9.8 percent by a boyfriend or girlfriend, 16.1 by another friend, 7.2 percent by other acquaintances, and 23 percent by strangers; 28.8 percent was unknown. These statistics were based on 1994 data and are provided only for general comparison because their sources and scope differs from our data.

²² Our analysis adds to 99 because there were 5 Medicare claims in our sample that involved more than 1 alleged perpetrator.

²³ Section 1150B of the Act does not cover other medical facilities such as hospitals, group homes, or assisted living facilities.

The CoPs for hospitals require that hospitals follow State laws for mandatory reporting. Group homes and assisted living facilities are covered by State regulations regarding the reporting of potential abuse or neglect,²⁴ and their employees generally are covered by State laws for mandatory reporting.

The incidents of potential abuse or neglect associated with the Medicare claims we reviewed in our sample occurred in a variety of settings. Specifically, we determined that 12 of the 94 Medicare claims associated with incidents of potential abuse or neglect in our sample indicate that the abuse or neglect occurred at a medical facility. These medical facilities included nursing homes and SNFs (seven claims), group homes (three claims), long-term acute-care hospitals (one claim), and assisted living facilities (one claim).²⁵ On the basis of our sample results, we estimated that 3,330 Medicare claims were associated with incidents of potential abuse or neglect that occurred at medical facilities.²⁶

In addition, we determined that, of the 94 Medicare claims associated with incidents of potential abuse or neglect in our sample, 61 were associated with incidents that occurred at the Medicare beneficiaries' homes and 16 occurred at other people's homes or public settings, such as parks and alleys.²⁷ We were unable to determine where the remaining five incidents occurred (Figure 6 on the next page).

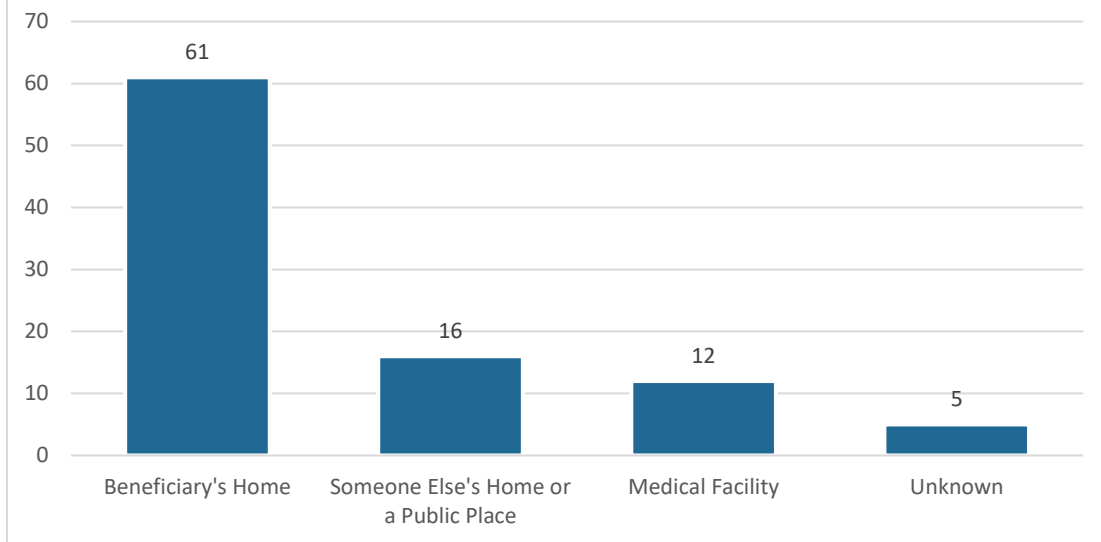
²⁴ For example, some States require group homes to report to the appropriate State agency any critical incident that involves emergency medical treatment of the group home residents.

²⁵ We classified assisted-living facilities as medical facilities because they are generally regulated or licensed by the States and frequently employ certified nursing assistants, who are certified or licensed by the States.

²⁶ The number of alleged perpetrators who were healthcare workers does not equal the number of potential incidents of abuse or neglect at medical facilities because some of the incidents at medical facilities involved alleged perpetrators who were not healthcare workers. For example, some of the alleged perpetrators at medical facilities were family members or other patients.

²⁷ According to the U.S. Department of Justice, Bureau of Justice Statistics' Special Report, *Violence-Related Injuries Treated in Hospital Emergency Departments* (Table 2), 28.9 percent of these injuries occurred at home; 9 percent on a street; 17.3 percent in stores, factories, and offices; 3.9 percent at schools; and 1.4 percent at recreational areas. The remainder, 39.4 percent, was unknown. These statistics were based on 1994 data and are provided only for general comparison because their sources and scope differ from our data.

Figure 6: Location of Incidents Associated With Sampled Medicare Claims for the Treatment of Potential Abuse or Neglect



A Representative Example of an Incident of Potential Abuse That Occurred at a Medical Facility

A beneficiary was evaluated and treated as an inpatient by a hospital for bruising and signs of potential elder abuse. The beneficiary was brought to the hospital by an ambulance from her nursing home where she received hospice care. A family member expressed concern about potential abuse and rape of the beneficiary. The beneficiary had injuries to the head, upper chest, abdomen, and both arms and legs. The beneficiary also had a serious bed sore on her lower back. The beneficiary suffered from Alzheimer's disease and was unable to provide an explanation of the injuries. The nursing home could not explain the injuries but denied that the beneficiary had been assaulted. The hospital treated the beneficiary for her injuries, contacted APS, and performed a rape evaluation. We determined that law enforcement was contacted, but we were unable to establish who made the referral. The beneficiary was discharged to a different nursing home. (See Photographs 2 and 3 on the next page.)

Photograph 2: Beneficiary's Facial Injury Sustained During the Incident of Potential Abuse



Photograph 3: Beneficiary's Wrist and Hand Injury Sustained During the Incident of Potential Abuse



LAW ENFORCEMENT WAS NOT ALWAYS ALERTED TO INCIDENTS OF POTENTIAL ABUSE OR NEGLECT

Many, but not all, of the incidents of potential abuse or neglect were reported to law enforcement (Figure 7 on page 19). Of the 94 Medicare claims associated with incidents of potential abuse or neglect in our sample, 17 were not reported to law enforcement by mandatory reporters even though all States require certain individuals to report suspected abuse, neglect, or exploitation of vulnerable adults. Sixty-nine of those incidents were reported

to law enforcement,²⁸ and we were unable to determine whether law enforcement was contacted for the remaining eight incidents.²⁹ On the basis of our sample results, we estimated that 9,294 Medicare claims associated with incidents of potential abuse or neglect in our population were not reported to law enforcement, including APS, local law enforcement, and the MFCU, as appropriate.

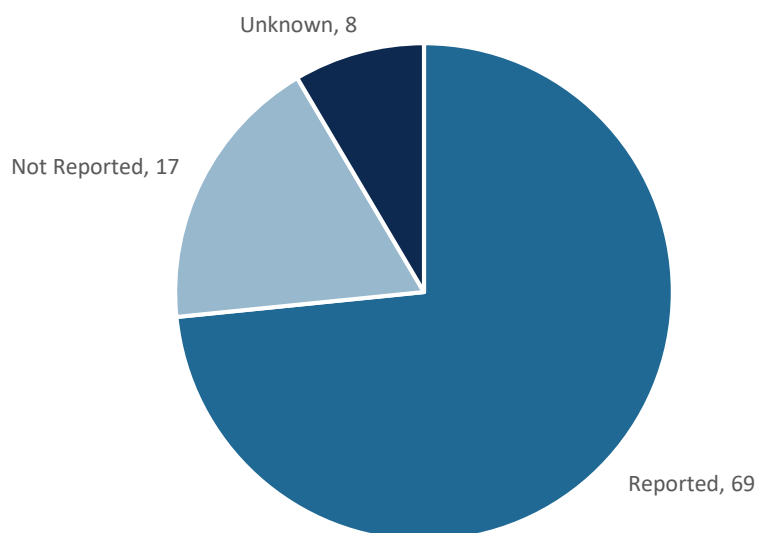
**A Representative Example of an Incident of Potential Abuse
Not Reported to Law Enforcement**

A beneficiary suffering from dementia and blindness was treated at a hospital as an outpatient after an alleged sexual assault at her nursing home. The beneficiary was found in her dementia lockdown unit with her adult diaper off and a male patient with his pants around his legs and his hand near her perineal area. The hospital received permission from the beneficiary's guardian to conduct a rape exam, which was limited to an external pelvic exam that did not show any signs of trauma or infection. The beneficiary denied any recollection of verbal, emotional, physical, or sexual abuse on that morning or in the recent past. The alleged perpetrator was transferred out of the nursing home for a psychiatric evaluation. The hospital staff stated that they would work with the beneficiary's social worker to ensure she would return to a safe facility. The beneficiary was returned to the nursing facility. There was no indication in the medical record that the treating hospital contacted APS or law enforcement. We contacted APS, law enforcement, and the MFCU and confirmed that all of these organizations were unaware of the incident.

²⁸ These incidents were reported to law enforcement by a variety of sources, including the Medicare beneficiaries, their families, and healthcare providers.

²⁹ We reported all 100 incidents associated with the Medicare claims in our sample to our Office of Investigations. We did not determine why the mandatory reporters did not contact law enforcement because this issue was outside the scope of our review.

Figure 7: Number of Medicare Claims Associated With Potential Abuse and Neglect in Our Sample That Were Reported to Law Enforcement



CMS’S FAILURE TO USE ALL MEDICARE CLAIMS DATA REPRESENTS A MISSED OPPORTUNITY TO IDENTIFY POTENTIAL CASES OF ABUSE OR NEGLECT

There is no Federal requirement that CMS detect unreported incidents of potential abuse or neglect.

CMS officials informed us that they did not extract data consisting of Medicare claims containing the 17 diagnosis codes related to abuse or neglect to identify unreported incidents of potential abuse or neglect during our audit period. However, CMS said it had taken corrective action related to data extracts based on the suggestions in our Early Alert.

Specifically, CMS stated:

In response to OIG’s early alert to CMS on August 24, 2017, CMS explored the possibility of . . . creating a model based on [SNF] Patient Abuse. However, using claims data, the model could not be constructed in such a way as to eliminate a significant number of false positives, successfully deal with small sample sizes, and avoid other fatal flaws. Thus, after spending several months trying to adjust the model, its development was halted. In its place, CMS incorporated information about patient harm (specifically, harm due to elder patient abuse)

into several of its OnePI³⁰ reports that are available to all OnePI users. These OnePI reports contain information relevant to SNF elder abuse and were built using, whenever possible, the metrics communicated in the OIG early alert detailing the preliminary results of their ongoing review of potential abuse or neglect of Medicare beneficiaries in SNFs.

We acknowledge that CMS has taken steps to identify incidents of Medicare beneficiary abuse and neglect in SNFs. However, the CMS reports containing such information are provided to organizations, such as Zone Program Integrity Contractors,³¹ involved with program integrity functions rather than organizations involved with public and patient safety. Furthermore, the current CMS data extract is limited to Medicare beneficiaries receiving SNF services who were treated for at least 1 of 39 diagnosis codes (Appendix I) that indicate potential abuse or neglect. However, the list of 39 diagnosis codes may not be complete. For example, it does not contain all codes that we included in our list of 17 from this review³² and does not include all diagnosis codes specific to child abuse or neglect.

Although CMS has designed a preventive control, we identified additional actions that CMS could take to better ensure that vulnerable beneficiaries are protected. Specifically, a data extract containing all diagnosis codes indicative of abuse or neglect could help ensure that incidents of potential abuse or neglect are detected and investigated.

RECOMMENDATIONS

We recommend that CMS:

- compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect;
- use the complete list of diagnosis codes to conduct periodic data extracts of all Medicare claims containing at least one of the codes indicating either potential abuse or neglect of adult and child Medicare beneficiaries;

³⁰ “One PI” is part of the CMS fraud detection system. The abuse and neglect diagnosis codes used by CMS are contained in Appendix M of the *One Program Integrity/One PI Inpatient SNF Comprehensive Fraud Investigation Report User Guide*, issued on February 17, 2018.

³¹ The Medicare Modernization Act created entities entitled Zone Program Integrity Contractors to perform program integrity functions in specific geographic zones for Medicare Parts A and B, durable medical equipment, home health, hospice, and Medicare-to-Medicaid data matching.

³² There were 5 diagnosis codes included in our list of 17 diagnosis codes in Table 1 that are not included on CMS’s list of 39 diagnosis codes that indicate abuse, neglect, or maltreatment: codes 99584, T7491XA, T7601XA, T7691XA, and V7181. The scope of this review involved only 17 diagnosis codes that indicated an initial encounter for abuse or neglect of an adult. There may be more diagnosis codes, and CMS is in the best position to identify those codes and create a complete list.

- inform States that the extracted Medicare claims data are available to help the States ensure compliance with their mandatory reporting laws; and
- assess the sufficiency of existing Federal requirements, such as CoPs and section 1150B of the Act, to report suspected abuse and neglect of Medicare beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional authorities as appropriate.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our fourth recommendation to strengthen regulatory requirements to report suspected abuse and neglect, but CMS noted that changes to section 1150B of the Act would require an act of Congress.

CMS did not concur with our first three recommendations. CMS said that although our review of claims data could provide helpful insight into past incidents involving potential abuse and neglect, “this data may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered.” CMS also noted that “over eighty percent of the sample cases” we identified in our audit “occurred in a home or public place, which do not fall under CMS’s jurisdiction for Federal oversight.” CMS said that it continues to prioritize its oversight of surveys and complaint work done by the State survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. CMS also stated that, “However, based on suggestions in OIG’s early alert on this topic, CMS is exploring claims data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this may be useful in efforts to address instances of potential abuse and neglect.”

CMS also described many other actions it has taken to address the potential abuse and neglect of Medicare beneficiaries. For example, CMS said that it has recently updated guidance to clarify the information needed to identify the most serious cases across all healthcare provider types to aid in quickly identifying and preventing these situations. CMS also said that it provides oversight validation surveys of States to determine whether State agencies are identifying deficiencies correctly, investigating compliance effectively, and meeting all other obligations.

CMS also provided technical comments on our draft report, which we addressed as appropriate. CMS’s comments, excluding the technical comments, are included as Appendix J.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS and law enforcement cannot adequately protect victims of abuse and neglect from harm if they do not know the harm is occurring. Accordingly, CMS's failure to use all Medicare claims data represents a missed opportunity to identify potential cases of abuse or neglect. In this regard, the lack of a data extract impeded the ability of CMS and public and patient safety organizations to pursue legal, administrative, and other appropriate remedies to ensure the safety, health, and rights of Medicare beneficiaries.

HHS's Strategic Plan³³ for fiscal years 2018 through 2022 stipulates that several of the strategic objectives are related to the health, safety, and well-being of individuals. For example, Strategic Objective 3.2 is to "safeguard the public against preventable injuries and violence or their results." Two of HHS's strategies to achieve this objective are to "expand knowledge about important abuse intervention models to enhance evidence-based services for older adults and adults with disabilities" and to "assess healthcare use and costs associated with violence and unintentional injury, including patient safety events that occur in healthcare settings, to inform actions to prevent injury and violence and describe the return on investment of public health action."

State laws constitute the majority of protections for beneficiaries abused or neglected outside of a Medicare facility, who are then treated at or by a Medicare facility or provider. CMS has vast amounts of Medicare data that could be useful in protecting these beneficiaries; it should work more closely with the States to provide access to these data so the States can police their programs more effectively.

In commenting on our draft report, CMS noted that claims data "may not be timely" because providers have up to 12 months after the date of a service to submit a claim. However, on average the Medicare administrative contractor received the claims in our sampling frame 32 days from the dates of service. In fact, the Medicare administrative contractor received more than 75 percent of all claims in our sampling frame in 30 days or fewer from the dates of service and more than 90 percent of all claims in our sampling frame in 90 days or fewer from the dates of service.

CMS also noted that more than 80 percent of the sample cases we identified in our audit "occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight." Nevertheless, the places where these beneficiaries were treated does fall under CMS's jurisdiction, and the treating health professionals who are being paid with Federal Medicare funds also fall under CMS jurisdiction.

³³ Although the Strategic Plan does not place any legal obligations on the HHS operating divisions, it does define its mission, goals, and the means by which it will measure its progress in addressing specific national problems. HHS Strategic Plan. Available online at <https://www.hhs.gov/about/strategic-plan/strategic-goal-3/index.html>. Accessed on October 16, 2018.

CMS further stated that it continues to prioritize its oversight of surveys and complaint work done by the State survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. However, based on previous OIG work, complaint data are not always addressed in a timely manner and may not be effective for our most vulnerable beneficiaries, especially if they lack a strong family advocate.

Although we acknowledge the number of actions that CMS has taken and plans to take to ensure incidents of potential physical or sexual abuse or neglect of Medicare beneficiaries are identified and reported, we respectfully disagree with CMS and continue to recommend the use of the Medicare claims data to identify and address potential physical or sexual abuse and neglect of Medicare beneficiaries.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered 34,664 inpatient and outpatient claims totaling \$99.6 million that contained at least 1 of 17 targeted diagnosis codes from January 1, 2015, through June 30, 2017. The 17 targeted codes indicated that the Medicare beneficiaries had suffered potential physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment.

We limited our review of internal controls to (1) gaining an understanding of the laws and regulations concerning the reporting of potential abuse or neglect of Medicare beneficiaries; and (2) determining whether CMS had internal controls in place, such as data matches or extracts to identify incidents of potential abuse or neglect.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance;
- extracted inpatient and outpatient claims for services provided from CMS's National Claims History file from January 1, 2015, through June 30, 2017, and that contained at least 1 of the 17 targeted diagnosis codes;
- identified a sampling frame of 34,664 inpatient and outpatient claims that contained at least 1 of the 17 targeted diagnosis codes from January 1, 2015, through June 30, 2017;
- selected a stratified random sample of 100 from the sampling frame of both inpatient and outpatient claims;
- obtained the medical records from the healthcare providers associated with our sample of 100 Medicare claims;
- reviewed those medical records to determine whether:
 - the record contained evidence of potential abuse or neglect,
 - the incident of potential abuse or neglect was reported to law enforcement,
 - the potential abuse or neglect occurred in a medical facility, or

- the alleged perpetrator of the potential abuse or neglect was a healthcare worker;
- determined whether any of the incidents of potential abuse or neglect involved a Medicare beneficiary who was also a veteran by contacting the U.S. Department of Veterans Affairs (VA);
- identified the portion of the total inpatient and outpatient claims that met each attribute described above;
- upon presentation of additional diagnosis codes related to children, conducted a 100-percent review of child abuse and neglect claims outside of our sample because of the gravity of the situation, including:
 - reviewed all Medicare claims data to determine whether any Medicare claims contained diagnosis codes that indicated potential child abuse or neglect,
 - obtained medical records for all nine claims identified, and
 - reviewed medical records to determine any evidence of abuse or neglect to a child, whether the incident was reported to law enforcement, the location of the incident, and the alleged perpetrator of the incident;
- contacted law enforcement to confirm whether they were informed of incidents of potential abuse or neglect for both sample item claims and child abuse or neglect claims;
- reviewed the Medicare claims data to determine whether any Medicare beneficiary died after an incident of potential abuse or neglect; and
- discussed the results of our review with CMS officials and the steps they have taken to identify incidents of potential abuse or neglect of Medicare beneficiaries.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015</i>	OEI-01-16-00330	September 2017
<i>Early Alert: The Centers for Medicare & Medicaid Services Has Inadequate Procedures To Ensure That Incidents of Potential Abuse or Neglect at Skilled Nursing Facilities Are Identified and Reported in Accordance With Applicable Requirements</i>	A-01-17-00504	August 2017
<i>Maine Did Not Comply With Federal and State Requirements for Critical Incidents Involving Medicaid Beneficiaries With Developmental Disabilities</i>	A-01-16-00001	August 2017
<i>Massachusetts Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00008	July 2016
<i>Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries</i>	A-01-14-00002	May 2016
<i>Review of Intermediate Care Facilities in New York with High Rates of Emergency Room Visits by Intellectually Disabled Medicaid Beneficiaries</i>	A-02-14-01011	September 2015
<i>Nursing Facilities' Compliance With Federal Regulations for Reporting Allegations of Abuse or Neglect</i>	OEI-07-13-00010	August 2014
<i>Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries</i>	OEI-06-11-00370	February 2014
<i>Criminal Convictions for Nurse Aides With Substantiated Findings of Abuse, Neglect, and Misappropriation</i>	OEI-07-10-00422	October 2012
<i>Unidentified and Unreported Federal Deficiencies in California's Complaint Surveys of Nursing Homes Participating in the Medicare and Medicaid Programs</i>	A-09-09-00114	September 2011
<i>Nursing Facilities' Employment of Individuals With Criminal Convictions</i>	OEI-07-09-00110	March 2011

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The target population consisted of nation-wide Medicare inpatient and outpatient claims that included at least 1 of 17 targeted diagnosis codes from January 1, 2015, through June 30, 2017. The 17 targeted codes indicated patients may have suffered physical abuse, sexual abuse or rape, neglect or abandonment, or other maltreatment.

SAMPLING FRAME

We obtained databases of Medicare claims data for all Medicare inpatient and outpatient claims containing selected diagnosis codes for Medicare beneficiaries from January 1, 2015, through June 30, 2017. The resulting sampling frame consisted of 34,664 claims totaling \$99,621,597 that included at least 1 of the 17 targeted diagnosis codes.

SAMPLE UNIT

The sample unit was a Medicare claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample containing three strata. Stratum 1 contained inpatient claims in which the admitting diagnosis code was one of the targeted codes. Stratum 2 contained outpatient claims in which the principal diagnosis code was one of the targeted codes. Stratum 3 contained claims in which one of the targeted codes was included on the claim but was not the admitting or principal diagnosis code.

Table 2: Sample Design and Size

Stratum	Claim Type	Target Code Is Admitting or Principal	Frame Size (Claims)	Sample Size	Dollar Value of Frame Units
1	Inpatient	Yes	728	35	\$5,178,728
2	Outpatient	Yes	12,644	35	4,293,281
3	Inpatient/Outpatient	No	21,292	30	90,149,588
Total			34,664	100	\$99,621,597

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG Office of Audit Services (OIG-OAS), statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame for each stratum. After generating the random numbers for each of these strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG-OAS statistical software to estimate the number of instances of potential abuse or neglect and each of the reporting and investigation attributes listed in Appendix D. We also used this software to calculate the two-sided 90-percent confidence interval for each of these estimates.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

CLAIM ATTRIBUTES FOR PROJECTION

Attribute 1: Medical record contained evidence of potential abuse or neglect

Attribute 2: Potential abuse or neglect occurred at a medical facility

Attribute 3: Alleged perpetrator of abuse or neglect was a healthcare worker

Attribute 4: Incident of potential abuse or neglect was not reported to law enforcement

Table 3: Sample Results by Strata

Stratum	Frame Size (Claims)	Sample Size	Attribute 1	Attribute 2	Attribute 3	Attribute 4
1	728	35	35	5	4	2
2	12,644	35	34	5	1	4
3	21,292	30	25	2	3	11
Total	34,664	100	94	12	8	17

Table 4: Estimates by Attribute
(Limits Calculated at the 90-percent Confidence Level)

Attribute	Statistical Estimates		
	Lower Limit	Point Estimate	Upper Limit
1	28,260 (82 percent)	30,754 (89 percent)	33,248 (96 percent)
2	1,284 (4 percent)	3,330 (10 percent)	5,376 (16 percent)
3	535 (2 percent)	2,574 (7 percent)	4,613 (13 percent)
4	5,963 (17 percent)	9,294 (27 percent)	12,625 (36 percent)

APPENDIX E: THE NUMBER OF MEDICARE CLAIMS ASSOCIATED WITH INCIDENTS OF POTENTIAL ABUSE OR NEGLECT OF MEDICARE BENEFICIARIES WHO WERE VETERANS

OIG remains committed to protecting the health and welfare of all Federal healthcare program beneficiaries. We are aware of specific concerns reported in the media regarding the care and treatment of our military veterans. We, therefore, believe it is important to identify these veterans whenever discussing potential abuse or neglect to provide policymakers with such information to help them in their decision making. Accordingly, we determined that of the 100 Medicare claims in our sample, there were 5 claims associated with Medicare beneficiaries who were also veterans (Table 5).³⁴ On the basis of our sample results, we estimated that there were approximately 2,511 Medicare claims associated with incidents of potential abuse or neglect that involved Medicare beneficiaries who were also veterans.³⁵

Table 5: Incidents of Potential Abuse or Neglect Involving Military Veterans

Diagnosis Code	Diagnosis Code Description	Incident Summary From Medical Record	Incident Location
T7601XA	Suspected adult neglect or abandonment, initial encounter	The beneficiary was transported to an ER after he was found dirty, covered with bugs, and on the floor in his room. The hospital contacted APS, and the beneficiary was transferred to a psychiatric unit.	Residence
T7611XA	Suspected adult physical abuse, initial encounter	The beneficiary was transported to an ER from a nursing home because of his combative behavior. He was found to have multiple rib fractures and a urinary tract infection. The hospital contacted APS, and the beneficiary was discharged to the nursing home.	Nursing Home
99581	Adult physical abuse	The beneficiary was transported to an ER and admitted to the hospital from an assisted living facility twice in a 3-week period. The initial admission was for abdominal and chest pain. The second admission was for continued pain and a fall. The beneficiary was found to suffer from an acute gangrenous gall bladder and died shortly after admission to the hospital.	Assisted Living Facility

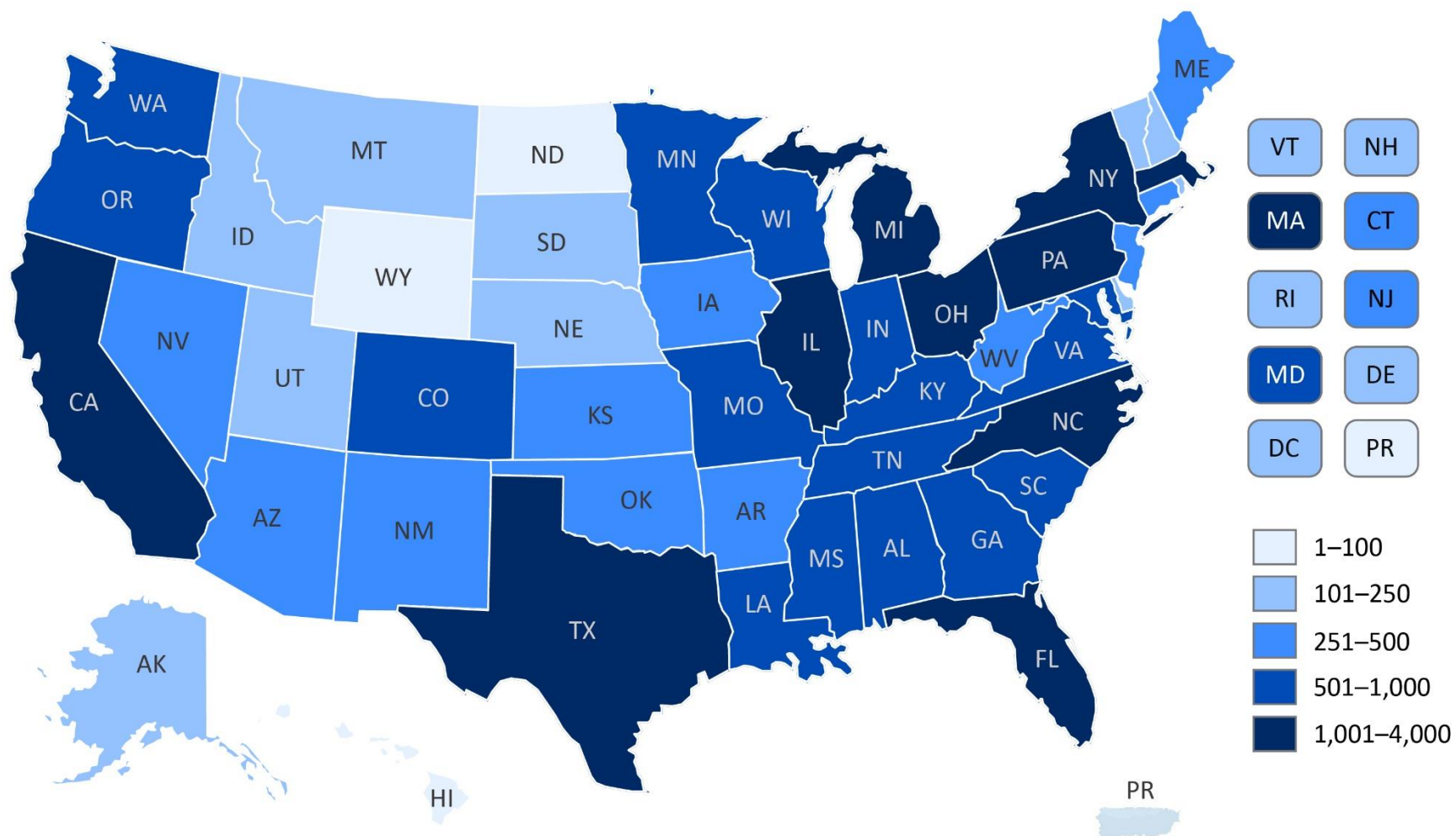
³⁴ One of these five veterans was also associated one of the six Medicare claims in which we were unable to determine whether they were for the treatment of injuries as a result of potential abuse or neglect because of insufficient or unclear documentation contained in the supporting medical records.

³⁵ The VA confirmed the veteran status for each of the Medicare beneficiaries associated with our 100 sampled items. Veterans' eligibility for VA health benefits is based on a variety of factors, including length of service, disability level, and income level.

99584	Adult neglect (nutritional)	The beneficiary was transported to an ER after he was found at his home in a disheveled state. He had pneumonia. It was determined that the beneficiary lives alone and a relative checks on him intermittently. The hospital contacted APS, and the beneficiary was discharged to a SNF.	Residence
99585	Other adult abuse or neglect	The beneficiary was transported to an ER for shortness of breath. A relative expressed concerns regarding potential elder abuse and potential financial exploitation. The hospital provided the relative with the APS contact information, and the beneficiary was discharged to his home.	Residence

APPENDIX F: THE NUMBER PER STATE OF MEDICARE CLAIMS FOR THE TREATMENT OF POTENTIAL ABUSE OR NEGLECT

Figure 8



APPENDIX G: DETAILED EXAMPLE OF AN INCIDENT OF POTENTIAL NEGLECT

A nonverbal beneficiary was treated as an inpatient at a hospital for potential neglect. The beneficiary was being cared for by a family member who had not sought additional medical assistance. However, another visiting family member noted that the beneficiary looked extremely thin and unwell and urged the caretaker to take the beneficiary to the hospital. Upon admission to the hospital, the beneficiary had multiple bruises, multiple scattered and serious bed sores (Photograph 3), at least two fractured ribs, severe malnutrition, pneumonia, and sepsis. The caretaker stated that the sores were from the beneficiary scratching herself and sliding around in her wheelchair. The medical records note that approximately 2 months before admission, the beneficiary was seen by a physician because the beneficiary's family noticed that the beneficiary was having difficulty swallowing and had ongoing weight loss. The physician did not find anything medically wrong with the beneficiary. The caretaker acknowledged that the beneficiary had lost weight but stated that the beneficiary had been staying awake all day and had been eating and drinking regularly. Around the same time, the beneficiary, who was previously able to independently toilet, developed copious watery diarrhea and was incontinent of bowel and bladder. At the time of admission, the beneficiary was bedbound. However, a month before the hospital admission, the beneficiary was able to walk independently using a walker. The hospital contacted APS and law enforcement, which were investigating the incident. The beneficiary died 12 days after being admitted to the hospital.

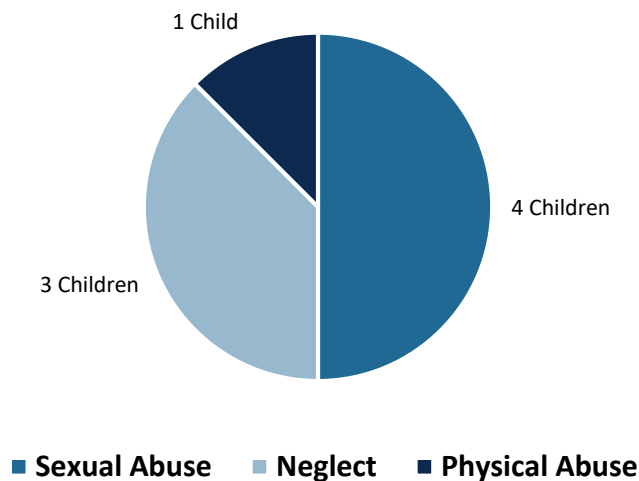
Photograph 3: Bed Sores on the Beneficiary's Lower Back, Buttocks, and Thighs



APPENDIX H: THE NUMBER OF MEDICARE CLAIMS INDICATING POTENTIAL CHILD ABUSE OR NEGLECT

OIG remains committed to protecting the health and welfare of all Federal healthcare program beneficiaries. We are aware of specific concerns reported in the media regarding the care and treatment of children. We, therefore, believe that it is important to identify children whenever discussing potential abuse or neglect to provide policymakers with such information to help them in their decision making. Accordingly, we searched Medicare claims data from January 1, 2015, through June 30, 2017, for any claims that contained 1 of 28 diagnosis codes³⁶ indicating potential child abuse or neglect and the beneficiary was under 18 years old at the time of the claim. These diagnosis codes were recommended to us by CMS. We discovered that there were a total of 8 Medicare beneficiaries who were under the age of 18³⁷ associated with 9 Medicare claims containing at least 1 of these 28 diagnosis codes. All of these children received Medicare benefits because they suffered from end-stage renal disease. These eight child Medicare beneficiaries were treated at a medical facility for potential sexual abuse, physical abuse, or neglect (Figure 9).³⁸ Table 6 contains a brief description of each of these incidents of potential abuse or neglect.

Figure 9: Diagnosis Code Category Indicating Potential Child Abuse or Neglect



³⁶ These 28 diagnosis codes do not include the 17 diagnosis codes indicating potential abuse or neglect of adults.

³⁷ The eight beneficiaries' ages ranged from 1 to 16 years.

³⁸ We contacted child protective services and law enforcement for each of the eight beneficiaries and confirmed that they were aware of these children and related incidents.

Table 6: Incidents of Potential Abuse or Neglect Involving Children

Diagnosis Code	Diagnosis Code Description	Incident Summary from Medical Record	Incident Location
Z0442	Encounter for examination and observation following alleged child rape	The beneficiary was transported to an ER from a dialysis facility after alleging that she had been raped. The dialysis facility reported the incident to law enforcement, and the hospital reported the incident to a State agency. The beneficiary was examined by the hospital staff and was discharged to her home.	Home and school
T7422XA	Child sexual abuse, confirmed, initial encounter	The beneficiary was transported to an ER after alleging that she had been raped. The hospital reported the incident to law enforcement and a State agency. The beneficiary was examined by the hospital staff and was discharged to her home.	Other private residence
T7492XA	Unspecified child maltreatment, confirmed, initial encounter	The beneficiary was transported to a clinic from a foster home for an initial medical evaluation. The beneficiary had previously been taken into State custody because of neglect by his previous custodial parent. The beneficiary was examined by the hospital staff and discharged to the foster home.	Home
T7602XA	Child neglect or abandonment, suspected, initial encounter	The beneficiary was transported to an ER from home for a medical evaluation. Child protective services ordered the medical evaluation on the basis of an allegation of neglect by the parents filed by another hospital. The beneficiary was examined by hospital staff, including a social worker, and was discharged to her home.	Home
T7602XA	Child neglect or abandonment, suspected, initial encounter	The beneficiary was transported to an ER from home because of high blood pressure. The hospital contacted child protective services. The beneficiary was admitted to the hospital pending further evaluation by child protective services of the beneficiary's home and of continued neglect.	Home
T7612XA	Child physical abuse, suspected, initial encounter	The beneficiary was transported to an ER from home after being physically assaulted by a family member. The hospital contacted law enforcement and the family member was arrested and a restraining order put in place. The beneficiary was treated for his injuries and discharged to his home.	Home

T7622XA	Child sexual abuse, suspected, initial encounter	The beneficiary was transported to an ER after alleging he had been sexually assaulted. The hospital contacted a State agency, examined the beneficiary, and discharged him to his home.	Unclear
T7622XA	Child sexual abuse, suspected, initial encounter	The beneficiary was brought to a hospital clinic after alleging she had been sexually assaulted. The hospital examined the beneficiary and contacted law enforcement. The beneficiary was then discharged, to which location was unclear.	Unclear

APPENDIX I: A LIST PROVIDED BY CMS OF 39 DIAGNOSIS CODES THAT INDICATE POTENTIAL ABUSE OR NEGLECT OF ADULT OR CHILD MEDICARE BENEFICIARIES

Diagnosis Code	Description
30284	Sexual sadism
99553	Child sexual abuse
99554	Child physical abuse
99559	Other child abuse and neglect
99580	Adult maltreatment, unspecified
99581	Adult physical abuse
99582	Adult emotional/physical abuse
99583	Adult sexual abuse
99585	Other adult abuse or neglect
E967	Perpetrator of child and adult abuse
F6552	Sexual sadism
T7401XA	Adult neglect or abandonment, confirmed, initial encounter
T7411XA	Adult physical abuse, confirmed, initial encounter
T7411XD	Adult physical abuse, confirmed, subsequent encounter
T7412XA	Child physical abuse, confirmed, initial encounter
T7412XD	Child physical abuse, confirmed, subsequent encounter
T7421XA	Adult sexual abuse, confirmed, initial encounter
T7421XD	Adult sexual abuse, confirmed, subsequent encounter
T7422XA	Child sexual abuse, confirmed, initial encounter
T7422XD	Child sexual abuse, confirmed, subsequent encounter
T7431XA	Adult psychological abuse, confirmed, initial encounter
T7431XD	Adult psychological abuse, confirmed, subsequent encounter
T7432XA	Child psychological abuse, confirmed, initial encounter
T7432XD	Child psychological abuse, confirmed, subsequent encounter
T7611XA	Adult physical abuse, suspected, initial encounter
T7611XD	Adult physical abuse, suspected, subsequent encounter
T7612XA	Child physical abuse, suspected, initial encounter
T7612XD	Child physical abuse, suspected, subsequent encounter
T7621XA	Adult sexual abuse, suspected, initial encounter
T7621XD	Adult sexual abuse, suspected, subsequent encounter
T7622XA	Child sexual abuse, suspected, initial encounter
T7622XD	Child sexual abuse, suspected, subsequent encounter
T7631XA	Adult psychological abuse, suspected, initial encounter
T7631XD	Adult psychological abuse, suspected, subsequent encounter
T7632XA	Child psychological abuse, suspected, initial encounter
T7632XD	Child psychological abuse, suspected, subsequent encounter
V715	Observation following alleged rape or seduction

Z0441	Encounter for examination and observation following alleged adult rape
Z0442	Encounter for examination and observation following alleged child rape



APPENDIX J: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

Date: APR -4 2019

To: Daniel R. Levinson
Inspector General
Office of Inspector General

From: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

Subject: Office of Inspector General Draft Report: "CMS Could Use Medicare Data to Identify Instances of Potential Abuse and Neglect" (A-01-17-00513)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report on the reporting, investigating, and tracking of incidents of potential abuse and neglect using Medicare claims data. Patient safety in all facilities that participate in the Medicare and Medicaid programs is a top priority for CMS.

CMS established in federal participation requirements that patients have the right to be free from all forms of abuse or harassment. These requirements apply to all health care facilities serving Medicare beneficiaries, including skilled nursing facilities and hospitals. However, as the OIG indicated, many incidents of potential abuse and neglect occur outside of healthcare facilities. Over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place. In cases where beneficiaries living and being cared for at home are brought to the emergency room, it is the responsibility of the individual healthcare providers to comply with the mandatory reporting laws for abuse applicable to their state. Penalties would be applied by the state, such as jail time or fines, for a practitioner that fails to report as required under state law.

Monitoring patient safety and quality of care in facilities serving Medicare beneficiaries is an essential part of CMS's oversight efforts and requires coordinated efforts between the federal government and the states. While OIG's review of claims data provides helpful insight into past incidents involving potential abuse and neglect, including injuries of unknown source, this data may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered.

To address the time-sensitive nature of abuse and neglect issues, CMS has a complaint intake and investigation process. CMS has agreements with state survey agencies to survey participating providers and suppliers and certify whether each entity complies with federal participation requirements. The state survey agencies not only inspect providers for compliance with Medicare health and safety standards, but also manage the intake of complaints and facility-reported incidents and conduct investigations accordingly. State survey agencies can conduct complaint investigation surveys at any time and anyone can file a complaint, including residents, family members, healthcare facilities, and anyone else who has reason to suspect abuse or neglect is taking place. Nursing home staff, and other mandated reporters under state laws, are required to report suspected abuse as specified under federal and state laws.¹ State agencies, including law enforcement and adult protective services, play an integral role in investigating complaints of abuse and neglect in a variety of health care settings and are responsible for reporting substantiated findings to local law enforcement, and if appropriate, to the Medicaid Fraud Control Units.

CMS has taken a number of actions regarding potential abuse and neglect. CMS recently updated guidance to clarify the information needed to identify the most serious, or immediate jeopardy, cases across all healthcare provider types, to aid in quickly identifying and ultimately preventing these situations. In addition to the guidance, CMS has developed an administrative tool that helps surveyors make sure they have the evidence needed to meet the criteria for an immediate jeopardy level determination of noncompliance. CMS also provides oversight validation surveys of states to determine whether state agencies are identifying deficiencies correctly, investigating compliance effectively, and meeting all other obligations. The CMS Regional Offices conduct formal assessments annually of each state survey agency's performance relative to measures included in the State Performance Standards System (SPSS). The SPSS provides a framework to organize and measure important aspects of state survey activities.

CMS recently revised the process for federal oversight of nursing home surveys conducted by state survey teams to add areas of concern that federal surveyors will examine to determine whether state surveyors are investigating for compliance effectively. In fiscal year 2018, CMS worked with states on three areas of concern: abuse and neglect, admission/transfer/discharge, and dementia care. In 2019, each Regional Office will again focus on identifying concerns related to abuse and neglect. They will also focus on facility staffing and other areas of improvement that are unique to the states in its region. CMS also recently launched an initiative to evaluate the entire SPSS program to identify ways to improve state performance. This is an ongoing, large-scale effort aimed at improving the efficiency and effectiveness of measuring and improving state performance.

¹ 42 C.F.R. §483.12(c)

CMS remains diligent in our duties to monitor facilities participating in Medicare and Medicaid across the country, as well as the state agencies that survey them, and we appreciate the ongoing work of the OIG in this area and will continue to work with them as we make improvements to our oversight efforts.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

CMS should compile a complete list of diagnosis codes that indicate potential physical or sexual abuse and neglect.

CMS Response

CMS does not concur with this recommendation. Of note, over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight. While CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect, CMS continues to prioritize its oversight of surveys and complaint work done by the state survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. Based on suggestions in OIG's early alert on this topic, CMS is exploring claims data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this information may be useful in efforts to address instances of potential abuse and neglect.

OIG Recommendation

CMS should use the complete list of diagnosis codes to conduct periodic extracts of all Medicare claims containing at least one of the codes indicating either potential abuse or neglect of adult and child Medicare beneficiaries.

CMS Response

CMS does not concur with this recommendation. Of note, over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight. While CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect, CMS continues to prioritize its oversight of surveys and complaint work done by the state survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. As mentioned above, claims review may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered. However, based on suggestions in OIG's early alert on this topic, CMS is exploring claims data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this may be useful in efforts to address instances of potential abuse and neglect.

OIG Recommendation

CMS should inform states that the extracted Medicare claims data are available to help the States ensure compliance with their mandatory reporting laws.

CMS Response

CMS does not concur with this recommendation. CMS shares the OIG's goal of improving the reporting of cases of potential abuse and neglect and will continue to work with states to support their efforts in addressing instances of potential abuse and neglect. CMS regulations require all facilities and their practitioners comply with the mandatory reporting laws for abuse and neglect applicable to their state, including compliance with timeliness requirements. Of note, over eighty percent of the sample cases OIG identified in their audit occurred in a home or public place, which do not fall under CMS's jurisdiction for Federal oversight. CMS continues to prioritize its oversight of surveys and complaint work done by the state survey agencies to address the time-sensitive nature of instances of potential abuse and neglect. As mentioned above, claims review may not be timely enough to address acute problems since providers generally have up to 12 months (one calendar year) from the date the service was provided to submit claims for services rendered. However, based on suggestions in OIG's early alert on this topic, CMS is exploring claims data with specific diagnoses indicating potential abuse and neglect at nursing homes and is determining how this may be useful in efforts to address instances of potential abuse and neglect.

OIG Recommendation

CMS should assess the sufficiency of existing Federal requirements, such as CoPs and section 1150B of the Act, to report suspected abuse and neglect of Medicare Beneficiaries, regardless of where services are provided, and strengthen those requirements or seek additional authorities as appropriate.

CMS Response

CMS concurs with this recommendation to strengthen regulatory requirements to report suspected abuse and neglect and will review our Conditions of Participation and interpretive guidance for opportunities to strengthen the current language to address reporting of suspected abuse and neglect to the appropriate authorities (such as the state survey agency, law enforcement or adult protective services). However, changes to section 1150B of the Act would require an act of Congress.

ACKNOWLEDGMENTS

This report was prepared in the Boston regional office under the direction of David Lamir, Regional Inspector General for Audit Services, and Curtis Roy, Assistant Regional Inspector General for Audit Services.

Shawn Dill, Senior Auditor, served as team leader for this audit. Other Office of Audit Services (OAS) staff from the Boston regional office who conducted the audit include Jennifer Godbois, Amy Harriman, Tori Janice, Richard Johnson, and Karen Lowe. Headquarters and OAS Centers for Medicare & Medicaid Services Baltimore Division staff provided support.